STATE OF MONTANA PROPOSAL IN RESPONSE TO SOLICITATION FOR STATE PROPOSALS TO OPERATE QUALIFIED HIGH RISK POOLS

AUTHORIZED INDIVIDUALS FOR PROPOSAL/CONTRACT NEGOTIATION

Commissioner of Securities and Insurance, Office of the Montana State Auditor

- Monica Lindeen
  Montana Commissioner of Securities and Insurance
  840 Helena Ave, Helena, MT 59601
  Email: mlindeen@state.mt.gov
  Phone: (406) 444-2040 Fax: (406) 444-3497

- Carol Roy
  Market Compliance Bureau Chief
  Montana Department of Insurance
  840 Helena Ave, Helena, MT 59601
  Email: croy@state.mt.gov
  Phone: (406) 444-3917 Fax: (406) 444-3497

Montana Comprehensive Health Association (Non-Profit Entity)

Cecil Bykerk
Executive Director
Montana Comprehensive Health Association
9643 Oak Circle, Omaha, NE 68124-2767
Email: oakoffice1@cox.net
Phone: (402) 501-8701 Fax: (402) 393-1645

To the extent a provision implicates the administrative services provided by the Montana Comprehensive Health Association's claims administrator, Blue Cross and Blue Shield of Montana (BCBSMT), the following individual is only authorized to negotiate any such provision on BCBSMT's behalf:

Blue Cross and Blue Shield of Montana, Inc.

Mary Belcher
General Counsel
Blue Cross & Blue Shield of Montana, Inc.
560 N. Park Avenue
P.O. Box 4309
Helena, MT 59604
Email: mbelcher@bcbsmt.com
Phone: (406) 437-5260 Fax (406) 437-7883

(a) CERTIFICATION

C.4 TECHNICAL APPROACH CONTENT

Please respond to the following questions regarding your State's proposed high risk pool program. You may submit additional information that demonstrates your proposal meets and/or exceeds the requirements of the Statement of Work outlined in Section A.4 and Summary of Qualifications found in Section C.3.

C.4.1 Describe in detail the State proposal for establishing and providing for the ongoing administrative functions of operating a high risk pool program. The description should describe how the State proposes to make the high risk pool program operational, including all sub-contracting relationships that may be included in the implementation plan and a proposed timeline for the implementation of the high risk pool program that includes the first date on which the program will accept enrollments and the first date on which the program will provide coverage for enrollees. If the State operates another high risk pool, describe how the State will segregate funding and expenditures for the two programs and track enrollees separately across all benefits and services.

If the proposal is to delegate the operation to a nonprofit entity, the State should clearly indicate if it proposes that HHS contract with the State (that will subcontract with the nonprofit) or proposes that HHS contract directly with the nonprofit high risk pool. If the State proposes that HHS contract directly with the nonprofit high risk pool, provide copies of all governing authorities of the nonprofit entity, including statutes, regulations, governance, and plan of operation.

As part of the technical approach, the State or its designated entity may subcontract with either a for-profit or nonprofit entity.

C.4.1 Response.

(a) General Response. The State of Montana (State) and the Montana Comprehensive Health Association (MCHA) confirm that they have the capacity and technical capability (either directly or through the use of designated subcontractors) to perform all necessary functions for the design, implementation, and operation of a qualified high risk pool, specifically the Montana Affordable Care Plan (MACP), as set

forth in this "Solicitation for State Proposals to Operate Qualified Health Risk Pools Solicitation."

Except as noted below, the State and MCHA agree to comply with the requirements set forth in Section A (Statement of Work) and C (Proposal Process) and acknowledge and agree to the applicability of the provisions set forth in Section B (Other Provisions):

(i) Section A.7 (4) requires the Contractor to submit an independently audited financial report detailing the finances of the high risk pool program on February 1, 2011, and each February 1 thereafter.

- Due to the closing year-end books' process, and the time period associated with the audit process thereafter, the State and MCHA proposes that MCHA will submit an independently audited financial report on June 30, 2011, and each June 30 thereafter.

(ii) Section A.11 states that the Contractor shall not discriminate based on race, ethnicity, religion, gender, age, or disability.

- Section A.4.2 (4) clarifies that premiums charged to enrollees in the qualified high risk pool may vary on the basis of age by a factor not greater than 4 to 1. Accordingly, the State, MCHA, and its subcontractors shall comply with Section A.11, except on the basis of age, by a factor not greater than 4 to 1.

(b) MACP Health Benefit Policy and Application

The proposed MACP health benefit policy and application, set forth in Appendices E and F, have been submitted to the State, and are pending approval. A copy of the final policy and application will be provided to HHS upon approval by the State.

(c) Montana Comprehensive Health Association. The State will establish and provide for the ongoing administrative functions of operating the MACP through its existing high risk pool, the Montana Comprehensive Health Association (MCHA). MCHA is a statutory body created by the Montana legislature and currently serves as the high-risk pool for uninsurable Montanans. MCHA also provides portability coverage for Montanans who leave qualified group coverage. Monica Lindeen, Commissioner of

Securities and Insurance, Montana State Auditor, has regulatory authority over the MCHA program, laws, and regulations.

MCHA was created in 1985 and incorporated as a nonprofit legal entity in 1986, pursuant to Title 33, Chapter 22, Part 15, Montana Code Annotated. The high-risk pool became operational on July 1, 1987. At that time the MCHA Association/Traditional Plan became available for uninsurable persons who qualified for coverage. Blue Cross Blue Shield of Montana (BCBSMT) has administered the self-funded, MCHA high-risk pool plans since the time of their inception.

MCHA is governed by an eight member Board of Directors (Board), as follows:

- One member from each of the five participating members (insurers) of the association with the highest annual premium volume of disability (health) insurance contracts, health maintenance organizations, health care services agreements or health services corporation contracts
- Two members at large who are participating members of the association
- One member at large to represent the public interest.

Cecil Bykerk is the MCHA Executive Director. (See Appendix A, biographical sketch.) Officers of the MCHA Board are Chester Lozowski of Continental General Insurance Company, Chair; David Hill of Assurant Health, Vice-Chair; Maryetta Bauer, Secretary and public interest member; and Robert Corn, Mutual of Omaha, Treasurer. Other members of the Board include Frank Cote of Blue Cross Blue Shield of Montana; Tanya Ask of New West Health Plan; Susan Witte of Allegiance Life & Health Insurance Co.; and J. Brian Angel of American Family Assurance Company. Carol Roy of the Montana Department of Insurance is the representative from the Commissioner of Securities and Insurance, Office of the Montana State Auditor (the CSI). The CSI oversees the Board's operation of the high risk pool. The oversight of the qualified high risk pool is expanded in the proposed Administrative Rules of Montana. (See Appendix C.) Each board member has specific expertise and knowledge in the operation of health insurance companies and high-risk pools.

(d) Delegation of Operation. As noted above, the State proposes to delegate the operation of the high risk pool to MCHA. With respect to this specific arrangement, the State proposes that HHS contract directly with MCHA. MCHA will

subcontract with BCBSMT to provide the administrative services required to operate the MACP.

In support of this proposal, the State has included a copy of MCHA's operating documents in Appendix B, which include:

- Montana statutes (Title 33, Chapter 22, Part 15, MCA)
- MCHA Articles of Incorporation
- MCHA Operating Rules
- MCHA Bylaws.

Proposed administrative rules pertaining to the administration of the qualified high risk pool program are delineated in Appendix C.

(e) Implementation Timeline. Working in conjunction with MCHA and BCBSMT, and assuming approval of this proposal and execution of a contract as contemplated by this solicitation, the State proposes that the MACP will accept enrollment on July 1, 2010. The State further proposes that the program will provide coverage for enrollees on July 15, 2010.

(f) Segregation of Funding and Expenditures. MCHA currently segregates the funding for its MCHA plans including the Traditional (uninsurable) Plan, the Portability (HIPAA) Plan, and the low income Premium Assistance Plan.

Similarly, MCHA and its subcontractor, BCBSMT, will ensure the segregation of funding and expenditures for the MACP in compliance with all federal requirements.

(g) Tracking of Enrollees/Reports. MCHA currently tracks enrollees by plan, i.e., Traditional Plan, Portability Plan, and Premium Assistance Plan. Similarly, MCHA will track enrollees in the MACP separately and distinctly from enrollees in other MHCA plans. See also C.4.2(6) Response, subparagraph (d) (Health Care and Costs Reports).

C.4.2 In response to the questions below, describe how the State will design a high risk pool program that will meet the basic requirements to operate the program as described in A.4.2 of the Statement of Work.

1) Describe the eligibility criteria that the qualified high risk pool will use to determine if individuals are eligible to enroll in the proposed high risk pool program.

C.4.2(1) Response. The eligibility criteria used by MCHA for the MACP reflects the same criteria contained in the solicitation and the State's proposed administrative rules. (See Appendix C.) A member:

- Must be a citizen of the United States or an alien legally present in the United States.
- Must be a resident of Montana.
- Must have a preexisting medical condition. (See Appendix D for the complete list of conditions that are considered presumptive or qualifying conditions.)
- Must have been uninsured for at least six months prior to applying for coverage

2) Describe the coverage and benefits to be offered by the qualified high risk pool. At a minimum, the response to this question must address the benefits elements contained in A.4.2 of the Statement of Work and include all benefit plan variations that may be proposed by the State.

C.4.2(2) Response.

The plan benefits for the MACP will comply with the benefit requirements contained in A.4.2 of the Solicitation. The qualified high risk benefit plan is a current MCHA health benefit plan which has been modified to meet the requirements in A.4.2. (Please reference Appendix E delineating the applicable coverage and benefits.)

MCHA's actuary[1] has examined the benefits of the plan and certified that the issuer's share of the costs is not less than 65 percent of the total cost of the plan based on the most recent information provided by insurance carriers operating in Montana. The rates have been set at 100 percent of standard market rates. The actuary has certified that the premiums comply with the applicable requirements.

3) How will the qualified high risk pool comply with the requirements to cover pre-existing conditions described in A.4.2.3?

C.4.2(3) Response. MCHA has redesigned its traditional plan application to include questions that solicit answers to the questions required by the MACP eligibility criteria. If an applicant is deemed eligible, no preexisting condition exclusion will be

[1] Margaret R. Onstott, FSA, MAAA

applied. If an applicant is deemed ineligible, the applicant will not be enrolled in the coverage. The application is attached as Appendix D.

In confirmation, MCHA will not deny enrollment based upon a pre-existing condition nor will it impose any pre-existing condition exclusions with respect to any coverage.

4) Describe how the qualified high risk pool will derive its premiums, including a description of its methodology in determining the standard risk rate.

C.4.2(4) Response.

Montana statute defines "average rate" for the purpose of determining the risk pool premiums as follows: "the average premium rates charged by the five insurers or health service corporations with the largest premium amount of individual plans of major medical insurance in force in this state." MCHA's actuary has completed this premium rate setting work. Please see Appendix G (Memorandum dated May 26, 2010) for a complete description of the premium methodology that will be used by the qualified high risk pool to derive its premiums.

5) Describe the cost sharing structure of the benefit package(s) proposed to be offered by the qualified high risk pool that complies with the requirements outlined in A.4.2.7.

C.4.2(5) Response. MCHA will offer one coverage option which contains a $2,500 deductible, with cost sharing of 70/30 for in-network services and 50/50 for out-of-network services. The maximum annual out-of-pocket limit will be $5,950. The copayments applicable to prescription drugs purchased through the Pharmacy Benefit Manager's point-of-sale claim system (by presenting the member identification card) will be applied to the maximum annual out of pocket limit. There is no deductible applied to prescription drugs and certain preventative benefits. For more detail, please see the health benefit plan in Appendix E.

6) If applicable, describe the provider network(s) proposed to be used by qualified high risk pool enrollees and demonstrate that the network(s) has a sufficient number and range of providers to ensure that all covered services are reasonably available and accessible in those networks.

C.4.2(6) Response.

(a) In-State Network Providers: Montana HealthLink PPO Network

The State and MCHA propose to use BCBSMT's existing Montana HealthLink PPO network as the network of choice for the MACP. The Montana HealthLink PPO network is the existing network that serves several hundred fully-insured groups and self-funded groups, including the existing MCHA plans.

The Montana HealthLink PPO network consists of a sufficient number and range of providers to ensure that all covered services will be widely available and accessible in the network. Specifically, the Montana HealthLink PPO network offers the MACP and its members the following benefits:

- One hundred percent of all Montana hospitals participate in the Montana HealthLink PPO network
- Ninety-four percent of Montana's physicians participate in the Montana HealthLink PPO network
- Eighty-four percent of Montana's outpatient surgical centers participate in the Montana HealthLink PPO network. Sixteen of 19 of Montana's outpatient surgical centers participate in the network and are located in the following major Montana cities: Butte, Bozeman, Missoula, Billings, Helena, Great Falls, and Kalispell/Whitefish.

(b) Out-of-State Network Providers: Blue Card Program

In addition, the MACP and its members will have access to out-of-state provider networks through the Blue Cross and Blue Shield Association's BlueCard program. This program has the single largest commercial provider network with participation by over 80 percent of all physicians (approximately 640,000) and over 90 percent of all facilities (approximately 5,500) within the United States.

BlueCard also gives members access to participating providers in foreign countries, currently in over 200 locations. Through BlueCard, members also have access to Blue Distinction Centers, with current networks for organ transplants, bariatric surgery, and cardiac care.

(c) <u>Network Savings</u>

In 2008, by virtue of its contractual agreements with healthcare providers, BCBSMT has provided network savings in excess of $310 million to its groups and

members. *Over the last five years, BCBSMT has been able to produce for its customers, network savings in excess of $1.2 billion.*

(d) Healthcare and Costs Reports

The State and MCHA will have access to the following reports that will delineate information and cost savings specific to the MACP as a means to continually evaluate claims experience and cost savings:

(1) Quarterly Healthcare Management Reports. These group specific reports will provide graphical and numerical information with respect to the claims experience for the MACP. In particular, the reports will document network savings to the members and pool as a portion of the distribution of payments.

(2) Summary Savings Report. The Summary Savings Report provides another layer of information regarding group network savings. The report provides an additional level of specificity as to the origination of the network savings, whether it is inpatient or outpatient institutional network savings, participating or non-participating professional providers.

(3) Five-Year Discount Analysis Report. The Five-Year Discount Analysis Reports will provide graphical and numerical information with respect to the amount and percentage of network savings that are realized as a result of utilizing the Montana HealthLink PPO network as it pertains to the MACP.

C.4.2(7) Describe the appeals and reconsiderations process that the qualified high risk pool proposes to make available to enrollees in the high risk pool program as per the description of section A.4.2.10.

C.4.2(7) Response. MACP members will have 180 days from the date of an adverse decision (or other determination) to appeal the decision. The health benefit policy will clearly outline the applicable appeals processes, as does each Explanation of Benefit. Generally:

- BCBSMT, as the claims administrator, will conduct a first-level review and issue a written decision within 30 days from receipt of all relevant medical records or information required to complete the review.
- If the member does not agree with the first-level decision, the member may request a second-level review by the MCHA Grievance Committee within 60 days

from the date of the first-level decision. MCHA will issue a written decision within 30 days from receipt of the appeal request and all related documentation.

- If the decision involved a finding that an applicant did not meet the eligibility criteria, the applicant may, after exhaustion of the internal appeal process, complain to the Montana Department of Insurance.

- If the decision involved a finding that the services or supplies were not appropriate and medically necessary (an adverse determination), the member may request an independent review of the adverse determination within 60 days from the date of the determination. The independent review process is governed by, and MCHA complies with, Title 33, Chapter 37, Montana Code Annotated. A copy of the statutes and applicable rules for independent review are included as Appendix F. MCHA is bound by the determination of the independent reviewer.

C.4.3 Describe the qualified high risk pool's proposed eligibility determination and enrollment standards as outlined in Section A.4.3.

1) **How will the qualified high risk pool develop and utilize an eligibility determination process that will assure that only individuals eligible for coverage, as described in Section A.4.2 of the Statement of Work, receive benefits from the program?**

C.4.3(1) Response. The eligibility and enrollment process for MACP members will be prescribed in writing and involve screening each application to ensure that every question is answered and that the appropriate documentation is provided to document and substantiate that an applicant meets all eligibility criteria.

If an applicant provides information about prior insurance coverage, the applicant's prior insurer will be contacted to verify (a) that the coverage terminated at least six months prior to the applicant's application for coverage and (b) the reason for the termination of coverage. If the applicant meets all eligibility criteria, the applicant will be issued coverage.

2) How will the qualified high risk pool obtain all of the information described in Section A.4.2 of the Statement of Work as part of the proposal process in the high risk pool program?

C.4.3(2) Response. MCHA has revised its application to solicit the required information as set forth in A.4.2 to determine if the applicant meets all eligibility criteria for participation in the MACP. The MCHA will use the same process that it currently uses for the existing traditional high risk pool plan to determine that the applicant has a preexisting condition that qualifies him or her for the new risk pool pursuant to federal law and Montana's proposed administrative rules. (See Appendix C.)

In addition, MCHA has contracted with an external actuary to evaluate the plan benefits and to develop premium rates for the new plan to ensure that the coverage meets the federal requirements. The standard risk rate will be determined pursuant to federal law, Montana statute and administrative rule. (See Actuary Attestation of Benefits and Premium rates in Appendix G.)

3) Describe the process that the qualified high risk pool will use to confirm that an enrollee is a citizen or national of the United States or an alien lawfully present in the United States.

C.4.3(3) Response. The State and MCHA will require a birth certificate, passport or other acceptable documentation as described by federal law to confirm that an applicant/enrollee is a citizen or national of the United States or an alien legally present in the United States. In addition, MCHA is in the process of determining whether it can partner with a state agency that currently has a system in place to verify citizenship or legal status. The State may also be able to use a state vital records verification system for individuals who were born in the state of Montana. In the alternative, MCHA may contract with an online service such as those offered by the United States Citizenship and Immigration Services to verify an applicant's legal status.

4) Describe the enrollment process that the qualified high risk pool proposes to use.

C.4.3(4) Response: If a complete application (inclusive of the first month's premium payment) is received on or before the 15th of the month, the effective date of coverage will be the first of the following month. If a complete application (inclusive of the first month's premium payment) is received after the 15th of the month, the effective date of coverage will be the 15th of the following month. Additional documentation may be requested if necessary to verify enrollment eligibility.

5) Describe the disenrollment process that the high risk pool plan proposes to use.

C.4.3(5) Response. MACP members will be disenrolled from the plan when any of the following situations occur, as allowed by law:

- A member obtains other creditable coverage.
- A member is no longer a resident of Montana.
- A member does not pay the monthly premium within the specified time for payment.
- A member dies.
- A member becomes Medicare eligible at age 65.
- A member fraudulently or intentionally misrepresents eligibility status.
- Pursuant to Montana administrative rule (Appendix C) if the qualified high risk pool no longer has sufficient funds to continue to pay claims, as determined by the MCHA board and the CSI.**

All terminations and disenrollments are subject to state law requirements, including the requirement that timely notice of termination be provided to the member. Please see the section entitled "Termination of Coverage" in the Health Benefit Policy for further details of the disenrollment process in Appendix E.

*When an individual become age-eligible for Medicare, a letter is sent instructing that individual to exercise his/her right to enroll in parts A, B, and D and Medicare supplement (or advantage) coverage during the open enrollment period in order to avoid penalties and also to gain the most cost-effective coverage. Once that individual is enrolled in Medicare, the qualified risk pool coverage will be terminated. Coverage will not be terminated if an individual is NOT Medicare eligible for some reason.

**The administrative rules provides that if the qualified risk pool closes for solvency reasons, the individuals covered in that pool would have access to coverage with no break in the MCHA traditional high risk pool. The rates set for the traditional high risk pool would apply.

C.4.4 Describe the customer service functions and standards that will be employed by the qualified high risk pool program. The description should include the qualified high risk pool's proposal for the staffing, hours of operation and

service levels that the qualified high risk pool will provide to enrollees in the qualified high risk pool.

C.4.4 Response. Customer service for the MACP and its members will be provided by the BCBSMT Customer Service team pursuant to MCHA's contract with the BCBSMT. The Customer Service team is located in Helena, Montana, and has a total of 53 customer service representatives.

(a) Staffing (MCHA Customer Service Team). The MACP members will be specifically served by the same team of customer service representatives that currently assists MCHA members. The team consists of 12 customer service representatives and a supervisor. The entire service team is trained to answer eligibility, benefits and claims questions specific to the various MCHA plans. The team will receive training on the requirements of the MACP, including information pertaining to eligibility, benefits, and claims, to ensure that they provide members with accurate and complete information.

(b) Hours of Operations. Customer service business hours are 8:00 a.m. to 6:00 p.m. on Monday, Wednesday, and Friday, and 9:00 a.m. to 6:00 p.m. on Tuesday and Thursday.

(c) Member Online Services Website.

(i) Direct Access to Member Information. MACP members may also access a Member Online Services' website to obtain a variety of health plan information, including, but not limited to:

- Eligibility details
- Benefit plan summary and description
- Deductible and out-of-pocket amounts
- Claim details and status
- Prescription claim information.

Using the online website, members may also:

- Order new ID cards.
- Order claims history reports.
- Submit privacy authorization information.

(ii) Direct On-Line Access to Customer Service. The Member Online Services website provides a "My Q & A" feature that allows a member to view Frequently Asked Questions and submit questions online to Customer Service. When the customer service representative responds to the question, the member receives an email alert containing a Member Online Services login link allowing them to view his/her private and secure answer.

(d) Customer Service Standards.

To ensure responsive customer service, the MCHA team has key performance indicators regarding accuracy, timeliness and abandon rates, as follows:

Key Performance Indicator	Goal
Accuracy	95 percent or better
Timeliness	95 percent or better
Abandon Rate	5 percent or less

C.4.5 Describe the technical support center to respond to health care and pharmacy providers for information that will be employed by the qualified high risk pool. The description should include the qualified high risk pool proposal for the staffing, hours of operation and service levels that the qualified high risk pool will provide.

C.4.5 Response. Providers used by the MACP will be served by the same team of customer service representatives that currently assists MCHA providers. The entire provider service team is trained to answer eligibility, benefits and claims questions specific to the various MCHA plans. The team will receive training on the requirements of the MACP, including information pertaining to eligibility, benefits, and claims, to ensure that they provide members with accurate and complete information.

(a) Staffing. The provider service team is composed of 13 customer service representatives and a supervisor. The entire service team is trained to answer eligibility, benefits and claims questions specific to the MCHA plans and members.

(b) Hours of Operation. As with the case for the MCHA customer service team, provider service business hours are 8:00 a.m. to 6:00 p.m. on Monday, Wednesday, and Friday, and 9:00 a.m. to 6:00 p.m. on Tuesday and Thursday.

(c) Provider Interactive Telephone Response System. Providers may access an interactive telephone response system that provides member specific information regarding eligibility and claims detail.

(d) Provider Online Services Website. Providers may also access an Online Services Website that offers access to a variety of health plan information, including:

- Overall benefit plan summary and descriptions
- Plan deductibles, out-of-pocket and lifetime maximums
- Claim status
- Line-by-line information about claims, including allowed amount, paid amount, date paid, and patient responsibility
- Provider Claim Remittance (PCR) Reports
- Pre-login access to frequently asked questions, online forms and provider manuals and policies.

(e) Provider Service Team Standards.

To ensure responsive customer service to providers, the provider service team has key performance indicators regarding accuracy, timeliness and abandon rates, as follows:

Key Performance Indicator	Goal
Accuracy	95 percent or better
Timeliness	95 percent or better
Abandon Rate	5 percent or less

C.4.6 Describe the qualified high risk pool's system for billing, collecting, and accounting for premiums.

C.4.6 Response.

(a) Billing. BCBSMT, the claims administrator, will bill MACP members on a regular monthly cycle. Individual bills for the MACP members will be generated on the tenth of the month for the following month's premium, and the premium is due the first of the following month. This payment cycle allows for member paid to dates to constantly be current, and maximizes claims processing and timeliness.

(b) Payment, Collection, and Cancellation. A MACP member's payment will be due on or before the due date of the bill. A member may pay through an electronic funds transfer (EFT). EFT transactions automatically pay the member's premium on or around the third of each month in one secure banking transaction. If a premium is not received by BCBSMT on or before its due date, it will be considered a late premium. If the premium has not been received within five days after its due date, a Cancellation Notice will be sent to the member advising that the member's coverage will be cancelled if payment is not received within 30 days. This process complies with applicable Montana law.

(c) Reconciliation. Payments for MACP members will be reconciled upon receipt to ensure appropriate accounting for all monies.

C.4.7 If the qualified high risk pool intends to develop and implement utilization and care management as part of the qualified high risk pool coverage, describe the utilization and care management processes that the qualified high risk pool proposes to use.

C.4.7 Response. Pursuant to MCHA's contract with BCBSMT, the claims administrator provides a fully integrated service line of medical management services headed by two medical directors, which will be fully available to the MACP and its members. The Integrated Healthcare Management program strives to provide a seamless continuum of care for members and groups from Medical Review, Wellness, Disease Management, Utilization Management, and Case Management.

(a) Medical Review. The Medical Review team is composed of 20 registered nurses and one licensed practical nurse. Other health care specialists are available

through Pro Peer and Medical Review Institute Inc., both URAC accredited organizations. BCBSMT has developed programs to provide information to members regarding authorization of services prior to those services being performed. Most providers utilize the prior authorization process to provide their patients with advice on coverage and or alternative covered services.

(b) Utilization Management. To ensure that health care services, procedures, and facilities are appropriate, timely, effective, and medically necessary, BCBSMT uses the following established utilization management criteria:

- Milliman Care Guidelines, including General Recovery Guidelines, Inpatient and Surgical Care Guidelines, Recovery Facility Care Guidelines, Psychiatric Guidelines
- Additional criteria sets of American Society of Addictive Medicine (ASAM)
- BCBSMT medical policy.

All of these criteria are filed with the CSI pursuant to Montana law.

The Utilization Review Staff is composed of registered nurses and behavioral health specialists who receive clinical information for initial point-of-care as well as ongoing certifications for appropriate inpatient care.

(c) Disease Management. MACP members will have access to the following disease management programs: Asthma; Chronic Obstructive Pulmonary Disease; Heart Failure; Coronary Artery Disease; Hypertension, and Diabetes.

The programs are designed to provide members with an understanding of their disease states, to ensure compliance with their recommended therapies, and to ensure that members are addressing all behaviors within their control (such as weight, activity, nutrition, etc.) to improve their health outcomes. As measured by individual surveys, individuals enrolled in case management for 2010 report a 99 percent satisfaction rate.

(d) Case Management. Case management is designed to provide a point of contact between patients and their health care providers, with the goal of helping deliver healthy outcomes while reducing costs for groups and members. Registered nurses and licensed clinical social workers act as patient advocates, coordinate

communication, assist in planning ongoing care, ensure care is delivered appropriately, and provide patient education.

The Case Management program includes (1) medical/surgical case management; (2) behavioral health case management; (3) complex case management; and (4) Neonatal Intensive Care (NICU) case management.

Case management cases are identified through daily population system surveillance and direct referrals from customer service, utilization review nurses, groups, members or their families, or providers.

BCBSMT subcontracts with Alere, an external case management vendor, for selected complex case management (CCM) and NICU case management services, both URAC and NCQA accredited organizations. The Complex Case Management program targets the one percent of the insured population who utilize about 34 percent of all health care dollars.

(e) Wellness. All MACP members will have access to a wellness website, "Well with Blue," which includes a Health Risk Assessment, wellness newsletters, exercise options, and healthy dietary tracking. The program encourages day to day participation in areas of health care where maintenance or improvement can contribute to overall health.

C.4.8 Describe the system for processing and paying for health and prescription drug claims that will be implemented by the qualified high risk pool. The description should include the basis for payment rates and the timeliness of payments to providers. The description should also include the point of sale claim system that will be utilized for prescription drug claims.

C.4.8 Response.

(a) System Overview. Pursuant to MCHA's contract with BCBSMT, the claims payment for the qualified risk pool will be administered by BCBSMT.

(i) QNXT Core Operating System. The Trizetto QNXT system is the core operating system used to process health claims. The system is a Microsoft-centric, rules-driven, user-configurable system. The advanced architecture is highly flexible and scalable, and integrates readily with other systems and add-ons such as industry leading claims bundling solutions. The system offers provider, eligibility, and claims

management and HIPAA compliant transaction front-end for processing claims and eligibility transactions.

(b) Pharmacy Benefit Management Point of Service System.

Prime Therapeutics (a subcontractor of BCBSMT) is used for pharmacy benefit management services. Prime's electronic point of sale claims processing is powered by SXC software. Members who present their card to a participating pharmacy will have their outpatient pharmacy claims electronically processed and will only be responsible for their member share at the point of sale. Prime's network contains over 61,000 pharmacies nationwide, including 98 percent of Montana pharmacies.

(c) Provider Compensation Methodologies. BCBSMT, the claims administrator, may use one or more of the following compensation methodologies:

(i) RBRVS Compensation. In the RBRVS system, a RVU (Relative Value Unit) is established for a code by determining the resource costs required to provide the service, i.e., physician's work, practice expense, and professional liability insurance. To determine the allowance for each code, the RVU is multiplied by the BCBSMT 2010 conversion factor, which is $59.50. Compensation is the BCBSMT allowance or the actual charge submitted on the claim, whichever is less. If the Medicare RBRVS system does not have an established RVU, BCBSMT may use a St. Anthony's RBRVS RVU established by the Cambridge Health Economics Group.

(ii) American Society of Anesthesiology (ASA) Compensation. Payment for the administration of anesthesia is made based on the American Society of Anesthesiology (ASA) methodology. The compensation method is a base and time unit calculation (base units plus time units multiplied by the conversion factor of $53.60). Anesthesia time is reported in minutes, and each 15-minute increment equals one unit of service.

(iii) Clinical Laboratory Compensation. The compensation method for clinical laboratory services is based on the Centers for Medicare and Medicaid (CMS) clinical laboratory fee schedule. Clinical laboratory services are compensated at 150 percent of the CMS clinical laboratory fee schedule. When no clinical laboratory fee is available from CMS, a clinical laboratory fee amount is determined by comparing similar procedures (when applicable).

(iv) Durable Medical Equipment Compensation. DME, oxygen, prosthetics, orthotics, and supplies allowances are based on the Centers for Medicare and Medicaid Services (CMS) Medicare Administrative Contractor (MAC) Jurisdiction-D DMEPOS fee schedule and the Parental and Enteral Nutrition Items and Services (PEN) fee schedule. The BCBSMT allowable fee is 100 percent of the DMERC fee schedule with some exceptions.

(v) Drug Compensation. Average Sales Price (ASP) is the basis for establishing drug code allowances. The source of ASP data is the Centers for Medicare & Medicaid Services (CMS) ASP Pricing File. When a drug code is not listed on the CMS ASP file, the following sources are used in the following order: (1) Noridian Administrative Services Radiopharmaceutical Pricing Update; (2) Redbook and its updates.

AWP is calculated by taking the low brand or median generic, whichever is less, invoice price, including shipping and handling. Special Consideration Drugs are certain high-cost medications for which a standard percentage markup overcompensates for the cost of the medication plus any associated costs related to the preparation and disposal of the product. The BCBSMT allowance is ASP plus 20 percent. For all other drugs that do not fall into the "Special Consideration Drug" category, the allowance is ASP plus 35 percent.

(vi) Manual Pricing Compensation. Codes without a standard fee schedule value for services, durable medical equipment or supplies are manually priced according to one of the following methods: (1) individual consideration based on review of the procedure and/or operative report; (2) comparison to a similar procedure(s); (3) 90th percentile of billed charges; (4) research of sources such as product manufacturers and distributors; (5) individual consideration based on equipment and/or supply provided; (6) comparison to similar equipment and/or supplies; or (7) invoice charge less shipping and handling. Compensation is the BCBSMT allowable fee or the actual charge submitted on the claim, whichever is less.

(d) Fee Schedule Updates. With respect to medical/surgical services, the following fee schedule components are updated May 1 of each year based upon CMS data: Clinical Lab, Anesthesia, DMERC, and Relative Value Unit. If there is a delay in

receiving information from CMS, the update is completed within 30 days upon receipt of the necessary information.

With respect to pharmaceuticals, drug updates occur on February 1, May 1, August 1, and November 1 of each year. If there is a delay in the web posting of the CMS ASP Pricing File, publication of the Noridian Administrative Services Radiopharmaceutical Pricing Update, or BCBSMT receiving information from Redbook, the update is completed within 30 days upon receipt of the necessary information.

(e) Timeliness of Payments to Providers and Members. BCBSMT, the claims administrator, processes 94.6 percent of its claims in zero to 14 days and 98.63 percent of its claims in 30 days (measured from the date a claim is received by BCBSMT to the date the claim is processed and ready for payment).

C.4.9 Describe the qualified high risk pool's proposed efforts to conduct outreach and marketing for the high risk pool program.

C.4.9 Response. MCHA will provide training and outreach to Montana health insurance agents to make them aware of the availability of this new coverage option. The MCHA website will be updated to include information about the MACP and will include an updated plan brochure, application for enrollment, and outline of coverage that will detail the benefits of the plan. The CSI will oversee the marketing efforts and supplement those efforts, when appropriate.

In addition, MCHA will also develop a public awareness campaign which will include the following activities, at a minimum:

- Newspaper advertising in every major newspaper in Montana
- Public and commercial radio statewide radio promotion
- Press conference in Helena, in conjunction with the Montana Department of Insurance, to generate statewide media coverage
- Statewide public service announcements.

C.4.10 Describe the process the qualified high risk pool proposes to use to identify and report to HHS instances in which health insurance issuers or group health plans are discouraging high-risk individuals from remaining enrolled in their current coverage in compliance with A.4.10.

C.4.10 Response. The State and MCHA, working in conjunction with BCBSMT, the claims administrator, will ensure that the necessary processes are in place to identify and report to HHS, any instances in which high risk individuals are being discouraged to continue their enrollment in their current coverage.

The State and MCHA anticipate that any such instances could be identified through various sources, including, but not limited to, the claims administrator's underwriting department, customer service department, compliance and ethics department, internal audit department, and the special investigations unit. The State and MCHA will ensure that training is provided to those individuals whom may be in the best position to detect such misconduct. In addition, the State may directly receive complaints from members regarding this issue. The CSI has a legal staff and a team of investigators that may investigate or prosecute any violations of Montana law or administrative rule. CSI has criminal justice authority to prosecute fraud, in addition to authority to regulate insurers, insurance producers and the high risk pool.

MCHA's Executive Director and the MCHA Board of Directors will work with the National Association of State Comprehensive Insurance Plans (NASCHIP) in the development of best practices in identifying and reporting such abuses.

C.4.11 Describe the procedures that qualified high risk pool proposes to implement to prevent, detect, and report incidences of waste, fraud, and abuse.

C.4.11 Response. The MCHA, by virtue of its contract with BCBSMT, has access to BCBSMT's anti-fraud program and related activities, identified below, which are already in place and fully functioning. This program would also encompass the MACP and its members.

(a) Special Investigations Unit (SIU). BCBSMT's commitment to fighting healthcare fraud is evidenced by the staffing of a full-time, dedicated Special Investigations Unit that has addressed fraudulent activity for more than a decade. SIU personnel specialize in the identification and investigation of fraud, and are credentialed as Certified Fraud Examiners, Accredited Healthcare Fraud Investigators, and Healthcare Anti-Fraud Associates.

The SIU has four primary responsibilities, as follows:

(1) Prevention of Fraud through the development and coordination of antifraud communication and education using newsletters, an antifraud website, and community outreach. Fraud is also prevented (when possible) through the identification and denial of fraudulent claims prior to payment.

(2) Detection of Fraud through case identification and referral system. This is accomplished in the following ways:

- Internally – Maintain fraud awareness in key departments through training, presentations, etc.
- Externally – BCBSMT prints a message on every Explanation of Benefits asking members to contact the SUI if they suspect fraudulent activity. BCBSMT also utilizes a toll-free fraud hotline and maintains an anti-fraud website with an online referral form.
- Proactively – The BCBSMT SIU also performs proactive audits in specific areas that are vulnerable to fraud.

(3) Investigation of Fraud using internal tools and activities (reporting, data mining, interviews, questionnaires, etc. The BCBSMT SIU also coordinates investigative activities with law enforcement and regulatory agencies.

(4) Resolution of Investigative Activities through judicial actions, administrative or civil actions, monetary recoveries, and the improvement of BCBSMT internal controls.

(a) Anti-Fraud Associations/Task Forces. BCBSMT is also a corporate member of the National Healthcare Anti-Fraud Association ("NHCAA"), the only national organization dedicated solely to the fight against healthcare fraud. The BCBSMT SIU and the CSI are core members of the Montana Healthcare Task Force, a group coordinated by the US Attorney's office that includes representation by all major law enforcement agencies, including the FBI, HHS/OIG, Medicaid Fraud Control Unit, the CSI, DEA, US DOL, and more. This group coordinates major healthcare fraud cases in Montana.

(b) State Investigation and Prosecution. In addition, as described above, the CSI has a team of attorneys and investigators that prosecute fraud, and will prosecute fraud and other code violations related to the qualified risk pool

C.4.12 Describe the system for routine monitoring and identification of compliance risks.

C.4.12 Response. Compliance risks are identified through a variety of means, including compliance/internal audit risk assessments and complaints from employees, members, or providers. In addition, MCHA and the State, in conjunction with and independent of BCBSMT, will also identify and monitor potential and actual compliance risks associated with the MACP and its members.

(a) Compliance and Ethics Program. BCBSMT's Compliance and Ethics Program (Program) has been developed to comply with the seven elements described in the United States' Sentencing Guidelines as components of an effective compliance and ethics program. The seven elements include the creation of detection and reporting mechanisms for program violations and evaluating the effectiveness of those mechanisms.

BCBSMT has implemented a Code of Business Ethics and Conduct (Code), applicable to its employees, officers, and directors, designed to ensure compliance with applicable federal and state laws and regulations. In particular, the Code prescribes a number of different ways to report compliance or ethics issues or concerns. An employee may raise concerns with the employee's direct leadership, the next level of leadership, Human Resources, the Compliance Officer, or any member of the Compliance and Ethics department. Board members are also directed to raise any ethical or compliance concerns with the Compliance Officer.

Employees, officers, and board members, who wish to remain anonymous, may use the toll-free Compliance HelpLine to leave information about a compliance or ethics concern. BCBSMT expressly prohibits in writing any form of retaliation or attempted retaliation against an employee who, in good faith, reports or cooperates in an investigation of any violation.

Annually, the Compliance and Ethics department prepares a compliance and ethics monitoring plan that identifies company processes, procedures, workflows, items, and other areas that relate to regulatory and/or compliance risks. Each item is reviewed for its relative risk of noncompliance and prioritized. Compliance and Ethics department

members work with the affected department(s) to obtain the information necessary to validate compliance with the requirement(s).

Specifically, to the extent ethical or compliance issues are identified in connection with the qualified high risk pool, such issues will be reviewed with the BCBSMT General Counsel and Compliance Officer for resolution and reported to the CSI and MCHA board, who will then decide what action is appropriate.

Performance Reporting/Internal Audit. BCBSMT provides routine monitoring and identification of compliance risks (which will encompass the MACP and its members) through its Performance Reporting (PR) team and Internal Audit (IA) department.

(i) Performance Reporting. The purpose of the PR Team is to provide timely and accurate performance reporting to the Blue Cross Blue Shield Association (BCBSA) regarding Member Touch-point Measurements (MTM). MTM is a set of performance measures that are maintained, monitored, and reviewed by the BCBSA in the following areas:

(1) Claims Timeliness. Claims timeliness is reported as the percentage of all claims processed to the "approved to pay" status within 30 calendar days. The timeliness standard is 97 percent.

(2) Claims Accuracy. Claims processing accuracy is reported as the percentage of all claims finalized accurately and of claim dollars paid accurately:

a. Processing Accuracy: 97 percent of claims processed accurately

b. Dollar Accuracy: 99 percent of paid gross dollars processed accurately

(3) Inquiry Timeliness. Inquiry timeliness is reported as the percentage of all inquiries resolved within seven calendar days. The inquiry timeliness standard is 90 percent.

(4) Inquiry Accuracy. Inquiry accuracy is reported as the percentage of all inquiries resolved accurately and completely. The inquiry accuracy standard is 99 percent.

(5) Enrollment Timeliness. Enrollment timeliness is reported as the percentage of subscribers (for new and renewal groups) that have the entire enrollment process completed by their effective date or within 30 calendar days of receipt of their completed application. The enrollment timeliness standard is 99 percent.

(6) Enrollment Accuracy. Enrollment accuracy is reported as the percentage of subscribers whose enrollment is completed accurately. The enrollment accuracy standard is 99 percent.

(ii) Internal Audit. The purpose of the IA team is to:

- Evaluate the reliability of management controls, which protect the assets of BCBSMT and its customers including MCHA.
- Conduct independent and objective consultation and appraisals, reviews and audits, based on annual risk assessments.
- Coordinate and/or participate as appropriate in external audits.

IA completes an annual risk assessment and based on this assessment develops a Master Audit Plan (MAP). All areas and processes within the company (enrollment, claims processing, membership accounting, finance, etc.) are included in the risk assessment and have the potential for audit. The risk assessment and MAP are subject to approval by the Audit Committee of the Board of Directors.

C.4.13 Describe the system the qualified high risk pool proposes to implement to coordinate benefits as described in A.4.13.

C.4.13 Response. The Claims Recovery Team will perform other party liability (OPL) and coordination of benefit (COB) functions for the MACP in compliance with its written procedures that define and clarify OPL processes, and as allowed by law.

(a) OPL Procedures. Based upon the OPL procedures, and in summary:

- Potential worker's compensation, subrogation cases, etc. are identified through diagnosis codes, procedures, and dollar thresholds on claims.

Cases are also investigated when BCBSMT is notified by members, providers, groups, attorneys, other insurance carriers, etc.

- The system produces accident letters of inquiry (LOI) that are sent to members based on sudden and serious diagnosis and occurrence codes on received claims.
- The claim that triggered the LOI will suspend for ten days pending a response from the member. Once the response is received, the claims will be processed according to the information received on the accident LOI.
- If a response is not received from the member within ten days, the pended claim will be denied for no response to the LOI.
- Each case is monitored and follow-up is performed on a regular basis.

(b) Coordination of Benefit Procedures. Based upon the COB procedures, and in summary:

- All coordination of benefit information is contained within the QNXT claims processing system, which allows prompt and timely payment of claims.
- Annually, the system will initiate and send a LOI upon receipt of a claim that indicates that the COB thresholds have been met for any member on a policy.
- The claim that triggered the LOI will suspend for ten days pending a response from the member. If there is more than one member on the policy, claims for the other members are not suspended or denied.
- If a response is not received from the member within ten days, the pended claim and any future claims will be denied for no response to the LOI.
- Additionally, if claims are received with other carrier information present, the claim processing system will compare this information to the member's LOI. If no other insurance is noted, the system will pend the claim to allow a claims analyst to investigate the other coverage and coordinate the benefits accordingly.

C.5 Budget Narrative

State shall provide a budget narrative as part of the cost proposal. The budget narrative should provide an explanation of each of the administrative costs identified in Table 1, including the basis of the cost estimates and indication of any sub-contracting arrangements the State intends to make to acquire administrative services.

States are also required to include an attestation from a certified actuary as to the actuarial soundness of the projections in the cost proposal, as those projections relate to the anticipated enrollment levels, premium revenue, and claims costs identified for each plan option identified by the State in Table 2. If the State proposes cost limiting strategies (such as enrollment limits) to keep the total program costs within the amount supported by premiums and available Federal funds allotment for the state, the State should describe those strategies in the Budget Narrative.

After review and potential negotiation between HHS and the proposer, the amount of projected costs to be reimbursed to high risk pool programs under these contracts will be the total of administrative and claims expenses, minus the premiums collected by the high risk pool programs. Each contract will contain a "not to exceed" amount available under the contract corresponding to each State's allotment. HHS will continually monitor actual State expenses in comparison to the cost estimates contained in the Cost Proposal and will negotiate with States to amend contracts accordingly to keep total program costs within the amount of funding available from the Federal funding allotment.

C.5 Response: The State will be subcontracting with Blue Cross Blue Shield of Montana (BCBSMT) to provide administrative services for the high risk pool.

Marketing and Outreach costs include mailing to agents describing the high risk pool program, eligibility criteria, and coverage options as well as costs associated with the marketing and publicity of the new high risk pool. Additional costs include agent referral fees and ongoing maintenance of marketing efforts. Estimated costs are based

on actual costs incurred relative to agent referral fees, mailings, and publicity. Ongoing maintenance is based on membership ratios.

Member Materials costs include the cost associated with providing the members information about the coverage or claims paid including explanation of benefits and member ID cards.

Customer Service costs includes the maintenance of a call center to provide prompt and accurate information and services to the high risk pool program members. Provider Relations includes the maintenance of a provider network capable of delivering services to the high risk pool members in a cost effective manner.

Information Technology costs includes the maintenance of systems used in support of the high risk pool and associated infrastructure support of those systems.

Eligibility/Enrollment costs includes verification of applicants' eligibility to ensure only eligible individuals are accepted for coverage. The information gathered will include name, address, date of birth, and Social Security number of the applicant and a verification of the citizenship of the applicant. Costs include the initial configuration of the benefits per established criteria and the ongoing maintenance of enrollees on the high risk pool plan of coverage. The costs also include the timely billing to enrolled membership of the monthly premium. Estimated costs are based on enrollment projections.

Premium Administration cost is not specifically identified in this line as the efforts are included in the other line items in Table 1 (attached). Specifically, premium determination is reflected in Actuarial Services; billing is in the enrollment process; and the collecting and cashiering of premiums is in Accounting Services.

Claims Processing costs includes costs associated with processing and paying claims for health and prescription drugs including a point-of-sale claims system for prescription drugs. Included is the development and implementation of a system for coordinating benefits for health and prescription drug claims with other payers. The costs also include the development, distribution and maintenance of member contracts. Estimated

costs are based on a combination of enrollment projections and claims ratios. Also included are access fees paid to out of state payers for claims processing through the subcontractors' BCBSMT Blue Card network.

Appeals and Reconsiderations costs include the establishment of procedures necessary for enrolled individuals to appeal eligibility and coverage determinations.

Legal Services costs include costs associated with legal issues arising over the course of the program. Also included is the establishment and implementation of an effective system for monitoring, identifying and mitigating compliance risks.

Accounting Services costs includes the costs associated with fund procurement, the collection and cashiering of member premiums, establishment and maintenance of specific reporting elements within existing financial systems, oversight and verification of explanation of benefits and provider claims registers, the development of reports to satisfy the requirements of the high risk pool, and procurement of services and goods needed to support the program. Also included is the cost of an annual audit of the program.

Actuarial Services costs includes the costs associated with the establishment of the premium rates and the continued monitoring of the expected claim payments to ensure that funding allotments will not be exceeded.

Procurement services costs are not specifically listed here as the costs are included as part of accounting services.

C.5 Maintenance of Effort Description and Table

The budget narrative should contain a separate section that describes how the State proposes to meet the maintenance of effort requirement set forth in section 1101(b)(3) of the Affordable Care Act. A State should provide a narrative description of its maintenance of effort strategy and also provide a table identifying State allocated funds and other current State high risk pool program revenues that supplemented premiums paid by current state high risk pool program enrollees in 2009. The narrative and accompanying table should demonstrate how the State will maintain that level of support of its state high risk pool program.

C.5 Response. The Montana Comprehensive Health Association (MCHA) is funded through a combination of premiums paid by enrollees and an assessment up to one percent of disability insurance premiums written by insurers in Montana. In addition, the Premium Assistance Plan receives state funds from the tobacco settlement and the MCHA receives grant funds from the federal Operational Grants to States for High Risk Pools (CFDA No. 93.780), and the Trade Assistance Act funds.

The MCHA enrollees pay premiums that are approximately 135 percent of the average market rate (AMR) as established by Actuary Margaret R. Onstott, FSA, MAAA.

The MCHA assesses up to one percent (pursuant to Mont. Code Ann. § 33-22-1513) of the direct written disability insurance premiums each year which are allocated to the MCHA. The assessment of insurance companies active in the disability insurance market in Montana has consistently funded the shortfall between the premiums collected and the claims paid for the enrollees. Disability insurers in Montana have been assessed the full one percent allowed by statute since 2000.

Montana receives revenue as a settling party to a Master Settlement Agreement (MSA) with four original tobacco companies and 47 subsequent companies. In accordance with the passage of Constitutional Amendment 35 by the Montana electorate in November 2000, the Legislature is required to dedicate no less than 40 percent of tobacco settlement money to a permanent trust fund. The remaining 60 percent was

deposited to the general fund. Due to passage of Initiative 146 by the electorate in November 2002, beginning in fiscal year 2004, 17 percent of the settlement funds are allocated to the Children's Health Insurance Plan (CHIP) now known as Healthy Montana Kids (HMK) and the MCHA. In addition, state statute (Mont. Code Ann. § 17-6-606) requires that a portion of this money go to the MCHA. A copy of the statute is included as Appendix B. The tobacco settlement funds have been used exclusively to fund the subsidies for low income people in the Premium Assistance Plan. This program is optional at the discretion of the board. Statute allows its operation only if funding is available from a source other than assessment dollars. Premium assistance has been paid primarily by federal grant dollars, and to a lesser extent, tobacco settlement dollars. If that funding ceases, the individuals in the Premium Assistance Plan will be covered by the Traditional Plan of the MCHA with no subsidy. The actual funds received by the MCHA are as follows:

FY Year	Amount
2004	$576,346.71
2005	$659,600.00
2006	$573,215.00
2007	$573,215.00
2008	$824,173.00
2009	$925,614.00

The state fiscal year runs from July 1st through June 30th.

The electorate and the Legislature have consistently dedicated funding to the MCHA as shown above. Commissioner of Securities and Insurance Monica J. Lindeen will continue to support the MCHA through inclusion of funding in the budget for the CSI for the coming legislative session. She will impress upon the legislature the need to maintain all current funding sources and levels.

Table 1

Administrative Costs					
Cost Category	**Annual Administrative Costs**				
	2010	**2011**	**2012**	**2013**	**2014**
Marketing and Outreach	$ 59,826	$ 36,125	$ 39,851	$ 35,792	$ -
Member Materials	$ 4,501	$ 2,399	$ 2,441	$ 2,484	$ -
Customer Service	$ 8,258	$ 39,749	$ 68,775	$ 87,569	$ 21,892
Provider Relations	$ 7,107	$ 14,641	$ 15,080	$ 15,532	$ -
Information Technology	$ 26,977	$ 43,295	$ 44,594	$ 45,932	$ 10,937
Eligibility / Enrollment	$ 10,006	$ 41,745	$ 68,019	$ 85,100	$ -
Premium Administration					
Claims Processing	$ 14,105	$ 63,785	$ 106,454	$ 133,602	$ 26,098
Appeals / Reconsiderations	$ 2,688	$ 14,730	$ 25,487	$ 32,452	$ 8,336
Legal Services	$ 4,836	$ 6,019	$ 6,114	$ 6,212	$ 864
Accounting Services	$ 29,678	$ 41,124	$ 42,110	$ 43,126	$ 17,231
Actuarial Services	$ 25,000	$ 15,000	$ 15,000	$ 15,000	$ 5,000
Procurement					
Personnel Expenses	$ 13,500	$ 18,000	$ 18,000	$ 18,000	$ 9,000
Overhead	$ 24,135	$ 49,148	$ 58,226	$ 64,508	$ 18,823
Other Administrative Costs	$ 3,239	$ 36,538	$ 93,786	$ 98,060	$ 26,116
Total	**$ 233,854**	**$ 422,298**	**$ 603,937**	**$ 683,370**	**$ 144,297**
					$ 2,087,756

Per Frank's conversation with Christina: This table will be revised prior to submission.

SUMMARY - TEMPORARY HIGH RISK POOL SUBMISSION (THRP-MT) 05/28/2010

State: **Montana**

Table 2

Year	Plan	(1-a) Average Enrollment	(1-b) Total Mbr Months	(2) Premium Revenue	(3-a) Total **Paid** Claims	(3-b) Total **Incurred** Claims	(4) Admin Costs	(5) = (3a) +(4) - (2) Total Claims Against Federal Fund Allotment	(6) = (3a) / (2) Inc. Loss Ratio	(7) = (3b) / (2) Paid LR
2010	**T-P2500**	248	1,485	623,700	1,002,973	1,609,143	38,390	417,663	258 percent	161 percent
2010								-	0 percent	0 percent
2010								-	0 percent	0 percent
2010								-	0 percent	0 percent
2010	Total	248	1,485	623,700	1,002,973	1,609,143	38,390	417,663	258 percent	161 percent
2011	**T-P2500**	410	4,920	2,211,048	5,511,171	5,864,136	326,747	3,626,870	265 percent	249 percent
2011								-	0 percent	0 percent
2011								-	0 percent	0 percent
2011	Total	410	4,920	2,211,048	5,511,171	5,864,136	326,747	3,626,870	265 percent	249 percent
2012	**T-P2500**	410	4,920	2,365,821	6,482,587	6,571,257	647,550	4,764,316	278 percent	274 percent
2012								-	0 percent	0 percent
2012								-	0 percent	0 percent
2012	Total	410	4,920	2,365,821	6,482,587	6,571,257	647,550	4,764,316	278 percent	274 percent
2013	**T-P2500**	410	4,920	2,531,429	7,399,774	7,556,945	955,179	5,823,525	299 percent	292 percent
2013								-	0 percent	0 percent
2013								-	0 percent	0 percent
2013	Total	410	4,920	2,531,429	7,399,774	7,556,945	955,179	5,823,525	299 percent	292 percent
2014	**T-P2500**			-	1,204,976		153,373	1,358,349		0 percent
2014								-		0 percent
2014								-		0 percent
2014	Total	-		-	1,204,976	-	153,373	1,358,349		0 percent

									State Allotment	Test
Total		16,245	7,731,998	21,601,481	21,601,481	2,121,239	15,990,722		16,000,000	Pass

Cross Check

Prems	7,731,998
Less Paid Clms	21,601,481
Less Admin	2,121,239
Net Loss	(15,990,722)

Total Inc. LR	Total Paid LR
279 percent	279 percent

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